

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/23/2012
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NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC - BICKNELL 1	STREET ADDRESS, CITY, STATE, ZIP CODE 628 W 7TH ST BICKNELL, IN 47512
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W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: October 10, 11, 15, 22 and 23, 2012.</p> <p>Provider Number: 15G202 Aims Number: 100243240 Facility Number: 000732</p> <p>Surveyor: Mark Ficklin, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed November 4, 2012 by Dotty Walton, Medical Surveyor III.</p>	W0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on interview and record review the facility failed for 5 of 9 investigations reviewed (clients #3, #4, #5, #6, #8), the facility failed to implement facility policy and procedures in regards to ensuring the administrator was informed of investigation results and corrective action was completed.</p> <p>Findings include:</p> <p>Record review of facility reportable incidents was done on 10/11/12 at 8:28a.m. The incident reports and investigations indicated: 1) Client #3 had a reportable incident report and investigation on 3/8/12 in which client #3 had choked and went to the emergency room. There was no documentation the investigation findings/summary had been reported to the facility administrator. 2) Client #5 had an allegation of staff abuse on 8/7/12. The facility investigation did not document when the facility administrator had been informed of the findings. 3) 8/11/12, staff gave client #6 the wrong medication. The investigation indicated staff would be retrained on medication administration. 4) 9/29/12, staff gave client #4 the dosage of</p>	W0149	<p>W149 Plan of Correction: The Investigation Summary Form will be revised to include the date the administrator was made aware of the results of the investigation. The administrator will be made aware within 5 days of the date the initial incident report was filed. Corrective actions will be implemented and documented on the Investigation Summary within 5 days of the date the initial incident was filed.</p> <p>Preventive Action: The Investigation Summary Form will be revised to include the date the administrator was made aware of the results of the investigation. All members of the investigation team will be trained by the Director of Residential and Adult Day Services to make the Director of Residential and Adult Day Services aware of the results of each investigation within 5 days and to document appropriately on the Investigation Summary. All members of the Investigation Team will be trained that corrective actions will be implemented and documented on the Investigation Summary within 5 days of the date the initial incident was filed.</p> <p>Monitoring: The Quality Assurance Coordinator will monitor the</p>	11/22/2012			

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	<p>medication. The investigation indicated staff would be retrained on medication administration. 5) 9/30/12, staff gave client #8 the wrong dosage of medication. The investigation indicated staff would be retrained. There was no documentation the facility had retrained the facility staff on medication administration.</p> <p>The facility policy and procedures were reviewed on 10/22/12 at 1:14p.m. The facility's 3/20/12 policy and procedure entitled "Neglect, Abuse, Battery, Exploitation, policy and incident reporting, and investigatory procedure" indicated: "An internal investigation will be completed. The results of this investigation will be reported to the Vice President of Program Services, the Executive Vice President, the President and external state organizations in accordance with state and federal regulations. These results will be reported within 5 working days of the alleged incident." The policy for abuse and neglect also indicated the facility staff were to be retrained (even if the allegation is unsubstantiated).</p> <p>Interview of staff #1 (Assoc. Director) on 10/11/12 at 11:42a.m. indicated the facility had not followed its policy procedures by not documenting when the Administrator was informed of the</p>		<p>accurate and timely completion of all abuse/neglect/exploitation/illegal activity investigations. The Administrative Assistant will monitor the accurate and timely completion of all other investigations.</p> <p>Date to be Completed By: November 22, 2012</p> <p>Responsible Party: Director of Residential and Adult Day Services</p>				

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	<p>investigation results and failed to ensure identified corrective action was completed.</p> <p>9-3-2(a)</p>				

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W0156	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview, the facility failed for 2 of 5 reportable incident investigations reviewed (clients #3, #5), to ensure reportable incident investigation results were reported to the administrator within five working days.</p> <p>Findings include:</p> <p>Record review of facility reportable incidents was done on 10/11/12 at 8:28a.m. The incident reports and investigations indicated: 1) Client #3 had a reportable incident report and investigation on 3/8/12 in which client #3 had choked and went to the emergency room. There was no documentation the investigation findings/summary had been reported to the facility administrator. 2) Client #5 had an allegation of staff abuse on 8/7/12. The facility investigation did not document when the facility administrator had been informed of the findings.</p> <p>Staff #1 was interviewed on 10/11/12 at 11:42a.m. Staff #1 indicated the investigation of client #3's 3/8/12 incident</p>	W0156	<p>W156 Plan of Correction: The Investigation Summary Form will be revised to include the date the administrator was made aware of the results of the investigation. The administrator will be made aware within 5 days of the date the initial incident report was filed. Preventive Action: The Investigation Summary Form will be revised to include the date the administrator was made aware of the results of the investigation. All members of the investigation team will be trained by the Director of Residential and Adult Day Services to make the Director of Residential and Adult Day Services aware of the results of each investigation within 5 days and to document appropriately on the Investigation Summary. Monitoring: The Quality Assurance Coordinator will monitor the accurate and timely completion of all abuse/neglect/exploitation/illegal activity investigations. The Administrative Assistant will monitor the accurate and timely completion of all other investigations. Date to be Completed By: November 22, 2012 Responsible Party: Director of</p>	11/22/2012	

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	and client #5's 8/7/12 incident investigations did not document when the facility administrator had been informed of the investigation results. 9-3-2(a)		Residential and Adult Day Services		

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W0157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview, the facility failed for 3 of 5 investigations of alleged neglect (medication errors) reviewed (client #4, #6, #8), to ensure appropriate corrective action was taken.</p> <p>Findings include:</p> <p>Record review of the facility's incident/investigations was done on 10/11/12 at 8:28a.m. The facility had the following documented reported incidents of neglect: 8/11/12, staff gave client #6 the wrong dosage of medication. The investigation indicated staff would be retrained on medication administration. 2) 9/29/12, staff gave client #4 the wrong dosage of medication. The investigation indicated staff would be retrained on medication administration. 3) 9/30/12, staff gave client #8 the wrong dosage of medication. The investigation indicated staff would be retrained. There was no documentation the facility had retrained the facility staff on medication administration.</p> <p>Interview with staff #1 on 10/11/12 at 11:42a.m. indicated the corrective action for the above incidents included staff retraining on medication administration.</p>	W0157	<p>W157 Plan of Correction: All members of the Investigation Team will be retrained on ensuring appropriate corrective actions are taken during each investigation. The members of the team will be trained that the Investigation Summary cannot be filed until documentation of appropriate corrective action is attached to the investigation. Preventive Action: All members of the Investigation Team will be retrained on ensuring appropriate corrective actions are taken during each investigation. The members of the team will be trained that the Investigation Summary cannot be filed until documentation of appropriate corrective action is attached to the investigation. Monitoring: The Quality Assurance Coordinator will monitor the accurate completion of each abuse/neglect/exploitation/illegal activity investigation and corrective actions. The Administrative Assistant will monitor the accurate completion of all other investigations and corrective actions. Date to Be Completed By: November 22, 2012 Responsible Party: Director of Residential and Adult Day Services</p>	11/22/2012			

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	Staff #1 indicated the facility had not completed or did not have documentation of staff retraining on medication administration. 9-3-2(a)				

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W0242	<p>483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.</p> <p>Based on record review and interview, the facility failed for 1 of 4 sampled clients (#2), to include training in client #2's annual Individual Program Plan (IPP) for her identified lack of dental hygiene skills.</p> <p>The findings include:</p> <p>Record review for client #2 was done on 10/15/12 at 11:02a.m. Client #2's 6/5/12 dental exam indicated "assistance with brushing" and generalized gingivitis. Client #2's 1/23/12 IPP did not have a training program to address her identified lack of dental hygiene skills.</p> <p>Interview of staff #1 on 10/15/12 at 1:02p.m. indicated client #2 was in need of dental hygiene skills training and did not have any formal dental hygiene training in place.</p> <p>9-3-4(a)</p>	W0242	<p>W242</p> <p>Plan of Correction: Client 2's individualized plan will be revised to include a training program for dental hygiene skills. The Manager/QMRP and Coordinator will be retrained on recognizing the need for programming.</p> <p>Preventive Action: The Manager/QMRP and Coordinator will be retrained on recognizing the need for programming.</p> <p>Monitoring: The Coordinator will monitor the accurate completion of each individualized plan.</p> <p>Date to Be Completed By: November 22, 2012</p> <p>Responsible Party: Director of Residential and Adult Day Services</p>	11/22/2012			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/27/2012

FORM APPROVED

OMB NO. 0938-0391

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W0249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review, and interview, the facility failed for 2 of 4 sampled clients (#1, #3), to ensure the clients' medication, communication and dining training programs were implemented when opportunities were present.</p> <p>Findings include:</p> <p>An observation at the group home was done on 10/10/12 from 4:17p.m. to 7:09p.m. Client #3 received his medication at 4:57p.m. Client #3 did not receive any medication training during the medication pass. Client #3 and client #1 had dinner at 6:24p.m. Clients #1 and #3 had yes/no cards and drink communication cards at their dinner place settings. During the meal, clients #1 and #3 were not prompted to use their communication cards. Also, during the meal, clients #1 and #3 did not take drinks while eating.</p> <p>The record for client #1 was reviewed on</p>	W0249	<p>W249</p> <p>Plan of Correction: The Manager and other staff will be retrained on active treatment/implementing programming when the opportunity arises. This training will include implementing each individual's medication, communication and dining plans.</p> <p>Preventive Action: The Manager and other staff will be retrained on active treatment/implementing programming when the opportunity arises. This training will include implementing each individual's medication, communication and dining plans.</p> <p>Monitoring: This Coordinator will visit the home at least once weekly to ensure programming is implemented.</p> <p>Date to Be Completed By: November 22, 2012</p> <p>Responsible Party: Coordinator</p>	11/22/2012			

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	<p>10/15/12 at 10:18a.m. Client #1's 5/25/12 individual program plan (IPP) indicated client #1's communication objective was to make yes/no responses and alternate liquids with foods during meals.</p> <p>The record for client #3 was reviewed on 10/15/12 at 12:24p.m. Client #3's 8/9/12 IPP indicated client #3's medication training program was to identify a picture of a pill from a picture of a non-pill. Client #3 also had training programs to communicate with cards yes/no and drink responses. Client #3 was also to be encouraged to take drinks between bites of food at meals.</p> <p>Interview of staff #1 on 10/15/12 at 1:02p.m. indicated clients #1 and #3's training programs should have been implemented at all opportunities.</p> <p>9-3-4(a)</p>			

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W0446	<p>483.470(i)(2)(ii) EVACUATION DRILLS</p> <p>The facility must make special provisions for the evacuation of clients with physical disabilities.</p> <p>Based on record review and interview, the facility failed for 1 of 5 clients (#4) with physical disabilities residing in the group home, to ensure client #4 had a documented plan of his evacuation needs during times of emergency.</p> <p>Findings include:</p> <p>Record review for client #4 was done on 10/15/12 at 11:50a.m. Client #4's 9/20/12 individual program plan (IPP) indicated client #4's diagnosis included, but was not limited to, Cerebral Palsy. Client #4's IPP indicated he used a wheelchair for mobility. Client #4 did not have his assistance needs with evacuating the group home identified.</p> <p>Staff #1 was interviewed on 10/15/12 at 1:02p.m. Staff #1 indicated client #4 used a wheelchair and needed staff assistance with mobility. Staff #1 indicated client #4 did not have an individual evacuation plan in place to direct staff with his evacuation needs.</p> <p>9-3-7(a)</p>	W0446	<p>W446</p> <p>Plan of Correction: Client 4's individualized plan will be revised to include his evacuation needs during times of emergency.</p> <p>Preventive Action: The Manager/QMRP will be retrained on accurately completing IPP's.</p> <p>Monitoring: The Coordinator will monitor the accurate completion of each IPP.</p> <p>Date to Be Completed By: November 22, 2012</p> <p>Responsible Party: Coordinator</p>	11/22/2012			